STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING _____ B. WING _____	C 02/16/2011

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NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00085809, IN00085922, and IN00086088.

Complaint IN00085809 - Substantiated. Federal/State deficiencies related to the allegations are cited at F253 and F254.

Complaint IN00085922 - Substantiated. Federal/State deficiencies related to the allegations are cited at F246, F253, F254, and F441.

Complaint IN00086088 - Substantiated. No deficiencies related to the allegation are cited.

Survey dates: February 13, 14, 15, and 16, 2011

Facility Number: 000131
Provider Number: 155226
AIM Number: 100274910

Survey Team:
Janet Stanton, R.N.--Team Coordinator
Rita Mullen, R.N.
Courtney Hamilton, R.N.
Michelle Hosteter, R.N. (2/14, 15)

Census bed type:
SNF--17
SNF/NF--90
Total--107

Census payor type:
Medicare--17
Medicaid--85
Other--5
Total--107

The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.

This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after 3/4/11.

RECEIVED

MAR - 7 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	3-4-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Sample: 7 Supplemental Sample: 11 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/22/11 by Suzanne Williams, RN	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure individual call light devices were within reach and available to summon staff for assistance, for 5 of 42 residents residing on the second floor nursing unit who were randomly observed [Residents #N, #O, #Q, #R, and #S]; and 6 of 35 residents residing on the fourth floor nursing unit who were randomly observed [Residents #I, #J, #K, #L, #M, and #P], in a supplemental sample of 11 residents observed. Findings Include: 1. The "Resident Care/Need Sheet" forms were provided on 2/14/11 by the Director of Nurses. She indicated these were the assignment sheets provided to each C.N.A. prior to their shift, and	F 246	**F 246** It is the practice of this facility to ensure that residents have the right is reside and receive services in the facility with reasonable accommodations of individual needs, and preferences, except when the health or safety of other residents would be endangered. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents call lights will be within reach or placed at the residents preferred placement at all times. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents utilizing call lights have the potential to be affected by this alleged deficiency **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** . Management staff will complete rounds on designated rooms at alternate times each business day to ensure that call lights are within reach, or at the residents preferred placement.	

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F 246	Continued From page 2 provided information related to the care of each resident. 2. During the initial observation tour on 2/13/11 at 5:45 P.M., the following was observed on the 4th floor nursing unit: A. Resident #J was observed in her bed which was next to the window, and furthest away from the hallway door. The resident was positioned on her right side, facing away from the doorway. The call light cord and hand button was observed laying on the floor under, and behind, the head of the bed. The "Resident Care/Need Sheet" for Resident #J indicated she was blind, was physically dependent on 1 staff person for A.D.L. [Activity of Daily Living] assistance, was resistant to care, and needed staff to call her name, explain care, and talk with her before care was given. B. Resident #K was observed sitting in his wheelchair, between his bed and the closet/sink area. The call light button was observed to be attached to the privacy curtain on the opposite side of the bed, and not in reach of the resident. In an interview at that time, the resident indicated he could not reach the call light. The "Resident Care/Need Sheet" form indicated the resident needed the physical assistance of 1 staff person for A.D.L. care. C. Resident #I was observed in bed. The call light cord and hand button was observed on the floor under the edge of the bed frame. In an interview, the resident indicated he was not	F 246	All staff have been in-serviced on proper placement of call bell cords. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Accommodation of needs CQI tool will be completed by DNS or designee weekly x 4, monthly x3, and then quarterly thereafter. **Compliance date: 03/04/11**	

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F 246	Continued From page 3	F 246		

sure where the call light was located. When the call light was pointed out, the resident indicated he did not think he could get to it.

3. During an observation tour on 2/15/11 at 6:05 A.M., the following was observed on the 4th floor nursing unit:

A. Resident #L was observed lying in bed. The call light cord was wrapped around the bottom of a 1/4 side rail, and the call button was hanging down to the floor.

In an interview at that time, the resident indicated she was not sure where the call light device was located.

The "Resident Care/Need Sheet" form indicated the resident was legally blind and required the physical assistance of 1 staff person for daily care.

B. Resident #M was observed lying in bed. The call light cord was observed wrapped around the bottom of a 1/4 side rail, with the hand button hanging down to the floor. The cord and button were covered by a blanket.

The "Resident Care/Need Sheet" form indicated the resident was physically dependent on 1 to 2 staff for daily care, mobility, and transfers.

4. During an observation tour on 2/15/11 at 6:15 A.M., the following was observed on the 2nd floor nursing unit:

A. Resident #N was observed in bed. The call light cord and call button were observed laying on the floor at the head of the bed.

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F 246	Continued From page 4	F 246		

In an interview on 2/14/11 at 8:45 A.M., L.P.N. #7 indicated Resident #N was socially inappropriate and not reliable for an interview.

B. Resident #O was observed sitting in a wheelchair between the bed and closet/sink area. The call light cord and call button was observed laying across the bed and in reach.

However, in an interview at that time, the resident indicated the call device was "usually not in reach--usually behind the bed."

5. The following was observed on the 4th floor nursing unit on 02/15/11, at 6:05 A.M.

Resident #P was observed lying on his left side in his bed. The call light was tied around the side rail on the on the right side of the bed. The call light was tied tightly around the side rail and was hanging off the side of the bed. It was out of the reach of the resident.

6. The following was observed on the 2nd floor nursing unit on 02/15/11, at 6:15 A.M.

A. Resident #Q was lying in the bed. The call light was laying at the foot of the bed and was out of the reach of the resident.

B. Resident #R was lying in bed, the call light was hanging off the head of the bed and way lying on the floor. The call light was out of the reach of the resident.

C. Resident #S was lying in bed. The call light was hanging off the head of the bed and was lying on the floor. The call light was out of the reach of the resident.

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F 246	Continued From page 5 This Federal tag relates to Complaint IN00085922. 3.1-3(v)(1)	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain floors in 2 resident rooms, and toilets in 5 of 15 resident bathrooms in a clean and sanitary manner; and failed to adequately label personal-use urinals with individual resident names on 1 of 4 nursing units. This deficiency had the potential to affect 2 residents on the 2nd floor nursing unit, 10 residents on the Alzheimer's/secured unit, and 18 male residents on the 4th floor nursing unit. Findings include: 1. On 2/14/11 at 12:30 P.M., the Maintenance Director provided an undated paper titled "Cleaning Guidelines." He indicated this paper outlined the daily, weekly, and monthly cleaning duties for the housekeeping staff. The guideline included, but was not limited to, the following: "Daily--Resident Rooms: Clean and disinfect restrooms, replenish soap paper towels and toilet tissue, clean/disinfect horizontal surfaces including commonly touched items, clean over bed light and bedside table,	F 253	**F 253** It is the practice of this facility that we provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** All bathrooms were inspected, and with bases cleaned, and caulk applied to those which needed sealed during the survey. All residents utilizing urinals were provided with new urinals, and new urinals will be provided on a daily basis. Residents rooms placed on a daily room clean schedule, and monthly deep clean schedule.	

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F 253	Continued From page 6 remove refuse/clean container/replace liner, sweep and mop floor vacuum carpet if applicable.... " 2. During an initial tour on 2/13/11 at 6:15 P.M. on the Augusta Cottage/secured unit, the toilets in rooms 302, 304, 306, 312 and 315 were observed to have dried yellow and blue substances on the back portion of the base of the toilets. Debris was also noted behind the toilets. 3. On 2/13/11 at 6:30 P.M., two dried noodles were found on the floor under the head of the bed in Room 310. During subsequent visits to the room on 2/14/11 at 9:15 A.M. and 1:30 P.M. and on 2/15/11 at 10:30 A.M., the dried noodles were observed to still be on the floor under the head of the bed. A review of the facility meal menu indicated beef and noodles were served on 2/8/11. During an interview with the Director of Maintenance and the facility Administrator, on 2/15/11 at 10:35 A.M., they indicated the floor needed to be cleaned. 4. On 02/15/11 at 10 A.M., the following was observed in resident room 202: There were several dried spaghetti noodles and food debris on the floor. Resident #C indicated he did not know how long the noodles and debris had been there. Review of the dietary menu indicated that spaghetti had been served on 02/12/11. There also was a large unidentifiable spot of dried tan liquid under the resident's bed. Resident #C indicated he did not know how long the spot had been there.	F 253	**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents residing in facility to have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Housekeeping staff were inserviced on proper cleaning of daily room cleaning, and of deep cleaning rooms. Sanitation procedure for urinals was changed to provide each resident who utilizes a urinal with a new urinal each day, and staff was inserviced on new procedure. Maintenance director will complete a room inspection on each room on date of scheduled deep clean or sooner if needed, and repair any issues.	

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F 253	Continued From page 7 The bedside table was observed to have two areas of dried food. Nurse #8 was observed to attempt to wipe the food off the table, but was unable to remove it. Resident #C indicated he did not know how long the food had been there. Resident #C was unsure when the room had been swept or mopped by housekeeping. 5. During an initial observation tour on 2/13/11 at 5:45 P.M., unlabeled urinals were observed as follows: Room 401--An unlabeled urinal was observed in a plastic bag, hanging from some pipes protruding from the wall above the toilet in the bathroom. Two male residents resided in the room. Room 406--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two male residents resided in the room. Room 407--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. Two male residents resided in the room. Room 411--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. One male resident	F 253	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** Facility Environment Review CQI tool to be completed weekly x4, monthly x3, and quarterly thereafter by the housekeeping/maintenance director or designee. Management team to round on designated rooms at alternate times each business day to ensure compliance. **Compliance date: 03/04/11**	

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F 253	Continued From page 8 resided in the room. Room 425--An unlabeled urinal was observed laying on a wheelchair seat. The wheelchair was being stored in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two female residents resided in the room. Room 430--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two male residents resided in the room. Soiled Utility room--Two "cleaned" urinals were observed hanging from a rod above the work counter. Both were unlabeled. One had the hard yellowish-white crusty material adhering to the inside and bottom surfaces. 6. In an interview on 2/13/11 at 6:15 P.M., the Director of Nurses indicated urinals were to be washed, sanitized, and dried in the Soiled Utility room. The urinals were not marked with individual resident names, to be returned to them, but were re-distributed randomly. This Federal tag relates to Complaints IN00085809 and IN00085922.	F 253		
F 254 SS=E	3.1-19(f) 483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition.	F 254		

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F 254	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to stock towels, washcloths, gowns, cloth incontinence pads and other resident care linen on each of 2 linen carts on each of 4 nursing units, in an amount and at the peak times of use, to provide for adequate resident care. This impacted 6 of 6 linen carts on 4 of 4 nursing units observed for adequate linens supplied for residents' usage, and had the potential to affect 107 residents residing in the facility. Findings include: 1. During an observation of the linen cart on the ventilator unit, on 2/13/11 at 5:40 P.M., there were two washcloths and no towels. During an interview on 2/13/11 at 6:30 P.M., R.N. #3 indicated she did not know when the laundry would bring more linens; there is no set time for deliveries from the laundry. 2. During an observation of the linen cart on Augusta Cottage, on 2/13/11 at 6:00 P.M., there were six washcloths and no towels. 3. The following was observed on the 2nd floor nursing unit on 02/13/11 at 5:35 P.M.: The linen cart outside of room #220 was fully stocked with blankets only. There was no other linen stocked on the cart. The linen cart outside of room #221 did not contain any towels. It contained six washcloths. There was a large amount of sheets, pads,	F 254	**F 254** It is the practice of this facility that clean bed and bath linens are provided in good condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** Linens were cleaned, and supplied to floors/nursing staff to provide to residents as needed. Additional linens purchased to build a par level for each floor so there will always be adequate linens on hand.	

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F 254	Continued From page 10 blankets, and gowns. The linen cart outside of room #226 contained one towel and seven washcloths. There was a large amount of sheets, pads, blankets, and gowns. The linen cart outside of room #204 did not contain any towels. The cart contained three washcloths and four gowns. There was a large amount of sheets, pads, and blankets. 4. The following was observed on the 2nd floor nursing unit on 02/14/11 at 9:25 A.M.: The linen cart outside of room #203 did not contain any pads. The cart contained seven towels and two pillowcases. There was a large amount of washcloths, sheets and gowns. The linen cart outside of room #227 contained three gowns and eight towels. There was a large amount of sheets, pillowcases and washcloths. 5. The following was observed on the 2nd floor nursing unit on 02/15/11 at 6:15 A.M. The linen cart outside of room #229 contained three gowns, two washcloths, and three towels. There was a large amount of sheets, pads, and blankets. 6. In an interview on 2/13/11 at 5:45 P.M., C.N.A. #5 indicated "we usually don't have a problem with linen but the past 3-4 weeks, we had problems on weekends. We keep running out. We had no linen this morning at 6 A.M., called laundry and we didn't get any till 9 A.M. They take a long time for linen to get to us."	F 254	**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents residing in the facility have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Par level counts were completed by housekeeping/laundry consultant, and linens were purchased to maintain those levels. Schedules were initiated on each shift to ensure timely delivery of linens. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** PAR level counts will be completed weekly x4 and then monthly thereafter to ensure adequate supply of linens are maintained. Facility Environment Review CQI tool to be completed weekly x4, monthly x3, and then quarterly thereafter by housekeeping/maintenance director or designee. **Compliance date: 03/04/11**	

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F 254	Continued From page 11 In an interview on 2/13/11 at 6:25 P.M., Laundry Assistant #6 indicated "I try to bring laundry up two or three times per eight hours shift. I know this isn't a lot of laundry right now...." 7. On 2/14/11 at 2:40 P.M., C.N.A. #1 was observed while providing incontinence care to Resident #E. In an interview at that time, the C.N.A. indicated that he had gotten a hospital gown off the floor cart that did not have ties. He indicated he would have to leave the room to find a gown that had ties because the resident preferred to wear a hospital gown during the night for comfort. When the CNA returned he apologized to the resident for it taking so long. He indicated he had to go to two different carts, on different floors, to find what he needed. The C.N.A. indicated this "happens all the time. " 8. During an initial observation tour on 2/13/11 at 5:45 P.M. on the 4th floor nursing unit, the following was observed: One 4-tier linen cart was observed in one of the main hallways across from Room 425. The cart had 11 washcloths, several pillowcases, 2 hospital gowns, 7 sheets, and 8 bath/bed blankets. Two staff members in the area indicated this was usual, and did not know when more clean linen would be delivered. They thought more linen supplies would be brought up from the laundry "later." A second 4-tier linen cart was observed in the second hallway next to Room 402. The cart had 4-5 washcloths, and a couple of blankets. There were no hospital gowns or towels.	F 254		

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	155226	A. BUILDING _____ B. WING _____	C 02/16/2011

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F 254	Continued From page 12 9. In an interview on 2/13/11 at 6:15 P.M., the Director of Nurses indicated there was no set time or schedule for clean linen to be brought up from the laundry. She indicated if one floor was short, they were to call other floors to borrow linen until the laundry department delivered more. If they were still short, staff were to call her, and she would call the laundry department to check. The Director of Nurses indicated it was her understanding that there was someone staffing the laundry 24/7, and would be available to bring up more linen supplies. In an interview on 2/14/11 at 11:00 A.M., the Administrator indicated he had terminated the Housekeeping/Laundry Supervisor the previous week for performance issues, and had designated the Maintenance Supervisor as an interim supervisor for those departments. In an interview on 2/14/11 at 1:15 P.M., the Maintenance Supervisor indicated he had been "covering" the Housekeeping/Laundry departments since the supervisor had been "let go" a week ago. He indicated he did a "drop" [put new towels, wash cloths, incontinence pads, etc. into service] every Monday, Wednesday and Friday. He indicated there were no set times for delivery of clean linen to each floor. The laundry staff member washed, dried, and folded whatever soiled linen that was delivered, and placed it on a transport cart. Once the transport cart was full, the laundry staff person would take it to each floor, and dispense clean washcloths, towels, gowns, blankets, cloth incontinence pads to each of the two smaller linen carts on each floor. There was no set amount of washcloths, towels, cloth incontinence pads, gowns, etc. to be stocked on each of the smaller linen carts on the	F 254		

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F 254	Continued From page 13 units. This Federal tag relates to Complaints IN00085809 and IN00085922. 3.1-19(g)(5)	F 254		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F441** It is the practice of this facility that an established infection control program is maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All male residents were reviewed for toileting preferences, and each resident utilizing a urinal was provided with a new urinal. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents who utilize urinals have the potential to be affected by this alleged deficient practice.	

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F 441	Continued From page 14 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain personal-use urinals in a manner to promote infection control and prevent cross-contamination by adequately cleaning, sanitizing, labeling, and returning to the same resident. This had the potential to impact 18 male residents on 1 of 4 nursing units. Findings include: 1. During an initial observation tour on 2/13/11 at 5:45 P.M., unlabeled urinals were observed as follows: Room 401--An unlabeled urinal was observed in a plastic bag, hanging from some pipes protruding from the wall above the toilet in the bathroom. Two male residents resided in the room. Room 406--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two male residents resided in the room. Room 407--An unlabeled urinal was observed in a plastic bag, which was hanging from some	F 441	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** All residents utilizing urinals will be provided with a new urinal each day. All staff have been in-serviced on infection control issues relating to urinal usuage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Environmental Safety –Nursing CQI tool will be completed weekly x4, monthly x3, and then quarterly thereafter. **Compliance date: 03/04/11**	

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F 441	Continued From page 15 pipes protruding from the wall above the toilet in the bathroom. Two male residents resided in the room. Room 411--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. One male resident resided in the room. Room 425--An unlabeled urinal was observed laying on a wheelchair seat. The wheelchair was being stored in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two female residents resided in the room. Room 430--An unlabeled urinal was observed in a plastic bag, which was hanging from some pipes protruding from the wall above the toilet in the bathroom. The urinal had a hard yellowish-white crusty material adhering to the inside and bottom surfaces. Two male residents resided in the room. Soiled Utility room--Two "cleaned" urinals were observed hanging from a rod above the work counter. Both were unlabeled. One had the hard yellowish-white crusty material adhering to the inside and bottom surfaces. 5. In an interview on 2/13/11 at 6:15 P.M., the Director of Nurses indicated urinals were to be washed, sanitized, and dried in the Soiled Utility room. The urinals were not marked with individual resident names, to be returned to them, but were re-distributed randomly. The Director of	F 441		

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F 441	Continued From page 16 Nurses indicated a "Quat" [Quaternary] sanitizer solution was used to "clean" the urinals, and that urinals with the crusty material adhering to the inside surfaces should have been thrown away. 6. On 2/15/11 at 8:00 A.M., the Director of Nurses provided a copy of an agenda for an inservice given to employees on 1/11/11. The title of the inservice was "Basic Infection Control Guidelines," and included, but was not limited to, the following: "... 7. After each and every use bedpans and urinal should be cleaned, sanitized, and re-bagged...." This Federal tag relates to Complaint IN00085922. 3.1-18(b)(1)	F 441		